Health Care Plan Comparison Worksheet

Plan Name	**1.**	**2.**	**3.**
Premium Amount	$	$	$
Type of plan (HMO, OAP, POS, PPO)			
Deductible (per year)	$	$	$
Copayment Required:			
Physician Office Visit	$	$	$
Prescription Drugs	$	$	$
Urgent Care	$	$	$
Emergency Room	$	$	$
Other	$	$	$
What is the Coinsurance % ? (ie: 90/10, 80/20 etc.)			
Out of Pocket Maximum	$	$	$
Are physicians you currently use signed up with the plan?			
Primary Care Provider	Yes No	Yes No	Yes No
Hematologist/HTC	Yes No	Yes No	Yes No
Other	Yes No	Yes No	Yes No
*Is clotting medication covered in this plan?**	Yes No	Yes No	Yes No
***Is it covered under Major Medical or Drug Plan**			
Do you have choices of factor providers?	Yes No	Yes No	Yes No
Can you use the HoG pharmacy with the plan?	Yes No	Yes No	Yes No
**If covered on Drug Plan what is the Tier or co-payment for each order?*			
Are there limits on the amount you can order?	Yes No	Yes No	Yes No
Is emergency care covered?	Yes No	Yes No	Yes No
Are there any limitations/restrictions in hospitalization coverage?	Yes No	Yes No	Yes No
If yes, what are they?			
Are your annual visits to the HTC covered?	Yes No	Yes No	Yes No
If you need a specific specialist who is not part of the plan, will the plan refer you to that physician?	Yes No	Yes No	Yes No
What will it cost?	$	$	$
Are any of the following services covered?			
Dental Care	Yes No	Yes No	Yes No
Vision Care	Yes No	Yes No	Yes No
Mental Health	Yes No	Yes No	Yes No
Chemical Dependency	Yes No	Yes No	Yes No
Preventive Health Screenings	Yes No	Yes No	Yes No
Other			
Are there clear directions on how to use the grievance/appeals procedure?	Yes No	Yes No	Yes No
Are you covered if you become ill away from home (including travel abroad)?	Yes No	Yes No	Yes No